MEDICAID PLANNING QUESTIONNAIRE
(SINGLE)

Date_____ File No. _____
Home Phone No._____ Business Phone No. _____
Cell Phone No._____ Fax No. _____
E-Mail Address_____

This form is extremely important. Your accuracy and completeness in responding will help me best represent you. Bring this information with you to your appointment.

A. CLIENT DATA

Full Name _____
(print name as shown on your checks)
Street Address _____
City_____ State_____ Zip_____
Birth Date_____ Social Security No. _____
U.S. Citizen? G Yes G No Veteran? G Yes G No

If widowed, please list name of spouse and date of death _____
Was your former spouse a Veteran? G Yes G No

If you or your former spouse is or was a Veteran, are you receiving Tricare? G Yes G No

B. MEDICAL DATA

1. HEALTH

Diagnosis_____

If you are already in a nursing home:

Name of Nursing Home_____

Date Entered_____

2. PHYSICIAN

Full Name of Primary Physician_____

Street Address_____

City_____ State_____ Zip_____

3. PHARMACEUTICAL PLANS

If you are a New Jersey resident, are you currently on PAAD (Pharmaceutical Assistance to the Aged and Disabled Program) or Senior GOLD? G Yes G No

If you are a Pennsylvania resident, are you currently receiving benefits under PACE? G Yes G No

If you re a Veteran, are you currently receiving prescription benefits from the Veteran's Administration? G Yes G No

C. MONTHLY INCOME

Net Social Security Benefits	$_____
Medicare Part B Deduction	G $93.50 G $106.00 G $143.40 G $162.10
Co-pay for Medicare Part D (if applicable)	$_____
Retirement Benefits (Gross)	$_____
Veterans Disability Income	$_____
Annuity Income	$_____
Rental Income	$_____
TOTAL MONTHLY INCOME	$_____

If there is a pension, please list the **gross pension amount**, including any monies taken out for federal income taxes, health insurance, or any other reason.

Do not include interest and dividend income on this form.

D. GIFTS

Have you made any gifts within the last five years to an individual or to a trust? G Yes G No

If yes, list below:

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Recipient_____ Date _____ Amount _____

Have you ever filed a Federal Gift Tax Return? G Yes G No

If yes, please state details

_____

_____

_____

E. CHILDREN (if applicable, include adult and minor children)

Name of Child_____ Gender: G Male G Female

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ Social Security Number_____

E-mail Address_____

Relationship: G Natural child G Adopted G Stepchild G Child born out of wedlock

Name of Child_____ Gender: G Male G Female

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ Social Security Number_____

E-mail Address_____

Relationship: G Natural child G Adopted G Stepchild G Child born out of wedlock

Name of Child_____ Gender: G Male G Female

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ Social Security Number_____

E-mail Address_____

Relationship: G Natural child G Adopted G Stepchild G Child born out of wedlock

Name of Child_____ Gender: G Male G Female

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ Social Security Number_____

E-mail Address_____

Relationship: G Natural child G Adopted G Stepchild G Child born out of wedlock

Name of Child_____ Gender: G Male G Female

Street Address_____

City_____ State_____ Zip_____

Home Phone Number_____ Work Phone Number_____

Date of Birth_____ Social Security Number_____

E-mail Address_____

Relationship: G Natural child G Adopted G Stepchild G Child born out of wedlock

Are all of your children in good health? G Yes G No

Are any of your children blind? G Yes G No

Are any of your children disabled? G Yes G No

Are any of your children receiving SSI or other form of government entitlement? G Yes G No

If yes: How much is the child's monthly payment? $_____

Is the child receiving Medicaid or Medicare? G Medicaid G Medicare

Do any of your family members have any problems with:

AIDS?	G Yes G No
Drug Addiction?	G Yes G No
Alcoholism?	G Yes G No
Spendthrift?	G Yes G No
Marital Difficulty?	G Yes G No

Do any of your children live with you in your home? G Yes G No

If yes, name of child_____

Does a sibling live in your home with you? G Yes G No

If yes, name of sibling_____

Are you a contributor to a 529 Plan? G Yes G No

If yes, please attach a statement of the 529 account.

F. CONTACT PERSON

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Cell Number _____ Fax Number _____

E-mail Address _____

G. MISCELLANEOUS

Do you have any other legal issues which I should be aware of? ☐ Yes ☐ No

If yes, please explain

_____

_____

H. REFERRAL

By Whom Were You Referred To This Office?

Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Cell Number _____ E-mail Address _____

Referral is: ☐ Attorney ☐ Financial Planner

☐ Previous Client of Scott M. Hanula, Esquire ☐ Doctor

☐ Social Worker Other _____

Have you visited our Website at www.hanulalaw.com? ☐ Yes ☐ No

Do you have any ideas for improving our Website? If so, please discuss.

H. CERTIFICATION

The undersigned hereby represents to Scott M. Hanula, Esquire that the information contained in this intake form is accurate and complete, and that the undersigned understands that Scott M. Hanula, Esquire will rely on this information. I understand that if the information contained herein is inaccurate or incomplete, the recommendations made by the law firm may not be appropriate.

Signature of Client or Client Representative:

MEDICAID PLANNING -ADDITIONAL INFORMATION

Last Name of Client_____ **File No.**_____

A. **ASSETS/LIABILITIES**

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
PERSONAL EFFECTS		
CHECKING		
SAVINGS		
MONEY MARKET		
CERTIFICATES OF DEPOSIT		
RESIDENCE (ASSESSED VALUE) BLOCK#_____ LOT#_____ EQ. RATIO _____ REM. FCTR _____		
OTHER REAL ESTATE BLOCK#_____ LOT#_____ EQ. RATIO _____ REM. FCTR _____		
AUTOMOBILE(S)		
BROKERAGE/CAP ACCOUNTS		

ASSET/LIABILITY	ASSET TOTAL	LIABILITY TOTAL
MUTUAL FUNDS		
STOCKS		
BONDS		
ANNUITIES		
CASH VALUE - LIFE INSURANCE		
TRADITIONAL IRA/RETIREMENT PLANS		
ROTH IRA		
NURSING HOME DEPOSIT		
PREPAID FUNERAL		
OTHER:		
OTHER:		
OTHER:		
TOTAL		

Residence Information

Purchase Price $_____

Purchase Costs
(title & escrow fees, real estate agent commissions, etc.) + $_____

Improvements + $_____

Selling Costs
(title & escrow fees, real estate agent commissions, etc.) + $_____

Accumulated Depreciation - $_____

Cost Basis = $_____

Have you owned the property for 2 of the last 5 years? G Yes G No

Have you occupied the property for 2 of the last 5 years? G Yes G No

Have you sold property within the last 2 years? G Yes G No

If yes:

What was the cost basis of the property? $_____

What was the sales price? $_____

Have you gifted property? G Yes G No

If yes:

Number of Donees _____

Amount of Credit Available _____

Other Real Property Information

Address of any real property other than personal residence:

(1)Street _____City _____State_____Zip_____

Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $_____

(2)Street _____City _____State_____Zip_____

Tax Block #_____, Lot #_____ (Can be obtained from Tax Bill)

What did you pay for this property including any improvements? $_____

Name of Homeowner's Insurance Company_____

Street Address_____

City_____ State_____ Zip_____

Phone No._____ Policy No._____

B. MONTHLY COST OF NURSING HOME

Monthly Nursing Home Cost $_____

Monthly Prescription Cost $_____

Monthly Incontinent Cost $_____

Monthly Medical Insurance Cost $_____

Monthly Other Cost $_____

Total Monthly Cost $_____

The nursing home is paid through _____(month/year).

C. LIFE INSURANCE

Name of Insurance Company_____ Policy #_____

Street Address_____

City_____ State_____ Zip_____

Type of Policy_____ Owner_____

Insured_____ Beneficiary_____

Death Benefit: $_____ Face Value: $_____ Cash Value: $_____

Name of Insurance Company ________________________ Policy #____________

Street Address ____

City ________________________ State _______________ Zip___________

Type of Policy ________________ Owner _____________________________

Insured ______________________ Beneficiary _________________________

Death Benefit: $________ Face Value: $____________ Cash Value:$________

Name of Insurance Company ________________________ Policy #____________

Street Address ____

City ________________________ State _______________ Zip___________

Type of Policy ________________ Owner _____________________________

Insured ______________________ Beneficiary _________________________

Death Benefit: $________ Face Value: $____________ Cash Value:$________

Name of Insurance Company ________________________ Policy #____________

Street Address ____

City ________________________ State _______________ Zip___________

Type of Policy ________________ Owner _____________________________

Insured ______________________ Beneficiary _________________________

Death Benefit: $________ Face Value: $____________ Cash Value:$________

Name of Insurance Company ________________________ Policy #____________

Street Address ____

City ________________________ State _______________ Zip___________

Type of Policy ________________ Owner _____________________________

Insured ______________________ Beneficiary _________________________

Death Benefit: $________ Face Value: $____________ Cash Value:$________